SURGERY FOR THE TREATMENT OF MORBID OBESITY - Page 1 of 2

INITIAL REPORT

Indiana State Department of Health

State Form 53321 (6-07)

Reset Form

DIRECTIONS - PLEASE READ BEFORE YOU BEGIN:

1. Print firmly and neatly.
2. Only use pens with blue or black ink.
3. Fill in circles like this: ● Not like this: ⊗ ✓ Mark mistakes like this: ●
4. Print capital letters only and numbers completely inside boxes. A 2 C 3
5. Please complete all items on form.

Section 1. Patient Information

Last Name

First Name **MI** **Phone Number** - -

Number & Street Address

City **State** **ZIP Code** -

County **Date of Birth (mm/dd/yyyy)** / / **Age (years)**

Sex:

○ Male ○ Female ○ Unknown

Ethnicity:

○ Hispanic or Latino ○ Not Hispanic or Latino ○ Unknown

Race (select all that apply):

○ Asian
○ Black or African American
○ American Indian or Alaska Native
○ Native Hawaiian or Other Pacific Islander
○ White
○ Other/Multiracial
○ Unknown

Section 2. Surgery Information

Baseline Measurements (before surgery):

BMI: **Waist Circumference:** . **Inches** **Previous Abdominal Surgery?** ○ Yes ○ No

Comorbidities:

ICD-9-CM Code . **ICD-9-CM Code** . **ICD-9-CM Code** . **ICD-9-CM Code** . **ICD-9-CM Code** .

Surgery:

Date of Procedure (mm/dd/yyyy): / /

Surgical Diagnosis (ICD-9-CM Code): .

Diagnosis, description:

Surgical Procedure (CPT Code):

Procedure, description:

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Section 2. Surgery Information (continued)

Name of Facility Where Surgery Performed

Facility Number & Street Address

City **State** **ZIP Code** -

Telephone Number - -

FAX Number - -

Surgeon's Indiana License Number

Name of Surgeon

Address

City **State** **ZIP Code** -

Telephone Number - -

FAX Number - -

Section 3. Additional Information and Comments

Comments:

Last Name of Person Completing Form

First Name of Person Completing Form

Phone Number - -

Date Form Completed (mm/dd/yyyy) / /